

## 607 CERTIFICATE OF DEATH

Reg. Dist. No.

00603  
21

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Fredemil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRED.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswil</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FRED. MEM. HOSP</u>		d. STREET ADDRESS <u>1 17 E. D Street</u>	
3. NAME OF DECEASED (Type or print) First <u>SUZANNE</u> Middle <u>MICHELE</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-57</u>
9. AGE (In years last birthday) <u>1/365 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>HARRY LEE ANDERSON</u>	
14. MOTHER'S MAIDEN NAME <u>DOLORES VIRGINIA LBY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ATELECTASIS</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u> DUE TO (c) <u>1 day</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-30</u> , 19 <u>57</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 MARKET ST.</u> DATE SIGNED <u>FRED. W. HELDRICH</u>			
ACTUAL SIGNATURE <u>Fred W. Heldrich</u> M.D.		PHYSICIAN'S NAME (Type) <u>FREDERICK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>	22d. LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Furt</u>		ADDRESS <u>Brunswick, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. J. G. Hecks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF REGISTRAR	

BUREAU V. E.

FEB 4 1957

RECEIVED

608

CERTIFICATE OF DEATH

00604

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick/Hagerstown, 519 W. Wash. St.</b>	
c. LENGTH OF STAY IN 1b <b>2 1/2 years</b>		d. STREET ADDRESS <b>526 Military Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Three Pines Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>V.</b> Last <b>ARMSTRONG</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cump</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Hagerstown, Md.</b>		Mrs. C. Austin Gardner - 915 W. Washington St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December, 1955</b> , to <b>Jan 11, 1957</b> , that I last saw the deceased alive on <b>Jan 11, 1957</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1-12-57</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Robert Turner</b>		<b>7 East Church Street - Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Browns Mill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Greencastle, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. E. Cline &amp; Son</b> ADDRESS <b>Frederick-Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 15 Jan 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Herb</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES EARL RAY		MALE		35	
DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 16 1968		BALTIMORE, MARYLAND		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HEART DISEASE		NATURAL		LAWYER	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
JAN 16 1933		MEMPHIS, TENNESSEE		MEMPHIS	
FATHER'S NAME		MOTHER'S NAME		CITY	
JAMES EARL RAY		MAUD RAY		MEMPHIS	
DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 16 1968		BALTIMORE, MARYLAND		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
HEART DISEASE		NATURAL		LAWYER	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
JAN 16 1933		MEMPHIS, TENNESSEE		MEMPHIS	
FATHER'S NAME		MOTHER'S NAME		CITY	
JAMES EARL RAY		MAUD RAY		MEMPHIS	

BUREAU V. 8

JAN 16 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

609 CERTIFICATE OF DEATH

Reg. Dist. No. 131

00605

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John A. Bagent</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-30-1888</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grain Mill</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Bagent</b>				14. MOTHER'S MAIDEN NAME <b>Belle ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-5656</b>		17. INFORMANT Address <b>E. Patrick St. Mrs. Chas. Angleberger (daughter) Frederick-Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma of lung</b> <b>162X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>265X</b> (b) <b>Bronchial pneumonia</b> DUE TO (c) <b>Diabetes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 weeks</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 27</b> , 19 <b>56</b> , to <b>Jan 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 5</b> , 19 <b>57</b> , and that death occurred at <b>5:37 AM</b> , from the causes and on the date stated above. <b>Bernard O. Thomas</b> M.D. <b>Professional Bldg.-</b> ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Jr.</b> <b>Frederick- Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-10-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West of Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Clinet Son</b> ADDRESS <b>Frederick-Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>7 Jan. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth	
John J. Frederick		Male		38		1919	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Maryland		Heart Disease		Jan 7, 1957		10:30 AM	
Usual Residence		Occupation		Manner of Death		Place of Death	
Baltimore, Md.		Teacher		Natural		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		City		County		State	
Jan 8, 1957		Baltimore		Baltimore		Maryland	

BUREAU V. 3

JAN 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00606

Reg. Dist. No. 131

610

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Frederick R. 306</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>Henrietta</u> Last <u>Beckett</u>		4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1930</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry J. Trout</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Meyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Beulah Trout</u>		Address <u>Frederick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of abdomen</u> 976X DUE TO <u>piercing stomach &amp; liver +</u> Conditions, if any, which gave rise to immediate cause (b) <u>transverse colon</u> DUE TO <u>transverse colon</u> cause last. (c) <u>transverse colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>11</u> p. m. <u>11/13</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bartonsville</u> (County) <u>Frederick</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B.D. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.D. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rory W. Barber</u>		ADDRESS <u>Bartonsville Md</u>	
24a. REC'D BY REGISTRAR <u>Jan 14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Heck</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JAN 21 1957

RECEIVED



611

CERTIFICATE OF DEATH

Reg. Dist. No.

00607

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>Middletown</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fred. Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Goldie</i> Middle <i>G.</i> Last <i>Bidle</i>				4. DATE OF DEATH Month <i>1</i> Day <i>17</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-17-1878</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>				13. FATHER'S NAME <i>William Guyton</i>			
14. MOTHER'S MAIDEN NAME <i>Laura Beachley</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>none</i>				17. INFORMANT <i>George A. Bidle</i> Address <i>Middletown, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary Occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>2-3 hrs</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>AUG 15, 1955</i> , to <i>1/10</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/17</i> , 19 <i>57</i> , and that death occurred at <i>7:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Kenneth C. Henson</i> M.D.				DATE SIGNED <i>1/18/57</i>			
PHYSICIAN'S NAME (Type) <i>Kenneth C. Henson</i>				ADDRESS (Street, city or town, state) <i>Middletown, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-19-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Middletown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co., Middletown, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>21 Jan 1957</i>			
24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>							

Dr. J. C. ...  
...

BUREAU V. B.

JAN 22 1957

RECEIVED

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

612

CERTIFICATE OF DEATH

00608  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>575 East Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>HENRY</b> Last <b>BIERLEY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1898</b>		9. AGE (In years last birthday) yrs. <b>58</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Service</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles E. Bierley</b>				14. MOTHER'S MAIDEN NAME <b>Annie Wachter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9918</b>		17. INFORMANT Address <b>Mrs. Pauline D. Bierley-see item #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ch. Carlos Rene Vasquez</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1</b> , 19 <b>57</b> , to <b>1-29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-28</b> , 19 <b>57</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>W. All Saints St., Frederick, Md.</b> DATE SIGNED <b>1/30/1957</b> ACTUAL SIGNATURE <b>U. G. Bourne Jr.</b> M.D. <b>W. All Saints St., Frederick, Md.</b> PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne Jr.</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>15 Feb. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1892		PLACE OF BIRTH Maryland	
MARRIAGE Married		EDUCATION High School		OCCUPATION Retired		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH 1957		PLACE OF DEATH Home		TIME OF DEATH 10:00 AM		TEMPERATURE 100.0		PULSE 80		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	
DATE OF DEATH 1957		PLACE OF DEATH Home		TIME OF DEATH 10:00 AM		TEMPERATURE 100.0		PULSE 80		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	

BUREAU V. 3

FEB 4 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

641

## CERTIFICATE OF DEATH

Reg. Dist. No.

93609

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>				c. LENGTH OF STAY IN 1b <u>14 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JAMES EDWIN BOWERS</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Jan 17 1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1881</u>	
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles W. Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Laura Etzler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Ailie Bowers, Walkersville, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>10 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1 Aug</u> , 19 <u>56</u> , to <u>17 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 Jan</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1/17/57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>				<u>WALKERSVILLE, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. C. Barton</u>				ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>21 Jan 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>			





90610

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH Jan 15 1957		PLACE OF DEATH Home	
RESIDENCE 1234 Main St, Baltimore, Md		OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF BIRTH Jan 15 1912		PLACE OF BIRTH Baltimore, Md	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married		PREVIOUS ILLNESS None	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESS John H. Harris		SIGNATURE OF WITNESS Mary E. Harris		SIGNATURE OF WITNESS John H. Harris		SIGNATURE OF WITNESS Mary E. Harris	

BUREAU V. S.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00611

CERTIFICATE OF DEATH

Reg.-Dist. No. 147

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winfield RD</u>		c. LENGTH OF STAY IN 1b <u>43 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winfield RD</u>		d. STREET ADDRESS <u>Winfield RD</u>	
3. NAME OF DECEASED First Middle Last <u>EMERSON D. BURRIER</u>		4. DATE OF DEATH Month Day Year <u>1 - 7 - 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1873</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Allen Z. Burrier</u>	
14. MOTHER'S MAIDEN NAME <u>Mary C. Lease</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Gertrude Burrier, Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Jan 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>57</u> , and that death occurred at <u>Winfield, Md.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>J. H. MESSLER</u>		DATE SIGNED <u>Jan 10 1957</u>	
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER</u>		22a. REC'D BY REGISTRAR <u>Jan 10 1957</u>	
22b. DATE THEREOF <u>1-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Mem. Park</u>	
22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>	
ADDRESS <u>Winfield, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Clarice Runkles</u>	

JAN 10 1957



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

613

## CERTIFICATE OF DEATH

00612  
187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13x22 Glenwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital D.O.A.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBIN DARLENE BYRD		4. DATE OF DEATH January 19 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 12 1956
9. AGE (In years last birthday) yrs. 3 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Chester Byrd		14. MOTHER'S MAIDEN NAME Hilda Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Chester Byrd, Glenwood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchopneumonia, Acute purulent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 12, 1956, to Jan 18, 1957, that I last saw the deceased alive on Jan 18, 1957, and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell M.D.		ADDRESS (Street, city or town, state) Mt. Airy, Md DATE SIGNED 1/19/57	
PHYSICIAN'S NAME (Type) W.B. Culwell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-22-1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR 22 1957 24b. REGISTRAR'S SIGNATURE Ely G. Hesk	

2006212XY7

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	

BUREAU V. S.

JAN 22 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,9 FilmG209 1-18-57 et

614

## CERTIFICATE OF DEATH

Reg. Dist. No.

00613

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Fred.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>none</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Cherry</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>ma</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/5/06</u> 51810 yrs.	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>houseman</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Yus Cherry</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS MARY C. JONES</u> Address <u>3214 Richmond Highway Turn Pike-Richmond</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of body of pancreas</u> DUE TO <u>extensive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>liver metastasis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>Jan 2, 1957</u> to <u>Jan 8, 1957</u> , that I last saw the deceased alive on <u>Jan 8, 1957</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Damazo M.D.</u>				DATE SIGNED <u>7 West 3rd St</u>			
PHYSICIAN'S NAME (Type) <u>FRANK DAMAZO M.D.</u>				<u>Frederick, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodland</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Nichols III</u> ADDRESS <u>24 W. All Saint</u>				24a. REC'D BY REGISTRAR <u>Jan 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Hark</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 644 CERTIFICATE OF DEATH

Reg. Dist. No.

00614  
147

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosemont</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rosemont</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Souder Road</u>			d. STREET ADDRESS <u>Souder Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Louise</u> Middle <u>Conner</u> Last			4. DATE OF DEATH Month <u>I</u> Day <u>26</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-1955</u>		9. AGE (In years last birthday) <u>1 yr. 3 mo. 5 da.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Richard Joseph Conner</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>Dorothy Mae Eury</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>R. J. Conner</u> Address <u>Brunswick, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.4</u> DUE TO <u>Brain tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral metastasis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>from tumor</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____			20g. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>1-26-1957</u> to <u>1-26-1957</u> , that I last saw the deceased alive on <u>1-26-1957</u> , and that death occurred at <u>8 p. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			ADDRESS (Street, city or town, state) <u>Brunswick, Md</u> DATE SIGNED <u>1-26-57</u>		
PHYSICIAN'S NAME (Type) <u>C. E. Pruitt</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. L. Felt</u>			ADDRESS <u>Brunswick, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>
			24b. REGISTRAR'S SIGNATURE <u>Eugenia Barker</u>		



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		M		35		1922		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		FEB 3 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
FEB 3 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		FEB 3 1957		NEW YORK		NEW YORK	
FEB 4 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		FEB 4 1957		NEW YORK		NEW YORK	

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FEB 4 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00615

645

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>JONES</b> Last <b>DADE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1856</b>	9. AGE (In years last birthday) <b>100</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Columbus Dade</b>				14. MOTHER'S MAIDEN NAME <b>Ann Mary Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Roger L. Dade, Jefferson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion with</b> <b>420.1</b> DUE TO <b>Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Generalized Arteriosclerosis</b> (c) <b>Advanced Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>12/21, 1956</b> to <b>1/4, 1957</b> , that I last saw the deceased alive on <b>1/3, 1957</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. Brice</b> M.D.				Jefferson, Maryland		DATE SIGNED <b>1/6/1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. T. Brice</b>				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herb</b>	

BUREAU V. S.

JAN 8 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

40616

646

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Detour</u>				c. LENGTH OF STAY IN 1b <u>38 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE LA RUE DEBERRY</u>				4. DATE OF DEATH Month Day Year <u>Jan 11 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Jonas Grim</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Fogle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-36-0300</u>			
17. INFORMANT <u>Mr. Elgie DeBerry, Detour, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asthma</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-11-</u> , 19 <u>57</u> , to <u>1-12-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-11-</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u>				ADDRESS (Street, city or town, state) <u>Union Bridge, Md.</u>			
DATE SIGNED <u>1-13-57</u>							
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>				ADDRESS <u>Union Bridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>				ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR <u>Elizabeth B. Heib</u>	
DATE <u>15 Jan 1957</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		45		M		W		1912		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JAN 15 1957		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JAN 15 1957		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
CORONARY THROMBOSIS		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	

BUREAU V. S.

JAN 16 1957

RECEIVED



## 615 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b Years <b>// Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>1016-A North Market Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ROSEANN</b> Last <b>DIVEN</b>				4. DATE OF DEATH Month <b>January 22,</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 April 1868</b>		9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Esterly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Dadisman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lewis H. Knock</b> (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Bronchopneumonia, bilateral</b> DUE TO <b>Congestive Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Abteriovascular Cardiovascular disease 5 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>10 days</b> <b>5 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/20/56</b> , 19 <b>56</b> , to <b>1/22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/21</b> , 19 <b>57</b> , and that death occurred at <b>6:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St., Frederick, Md.</b> DATE SIGNED <b>1-23-57</b>							
ACTUAL SIGNATURE <b>Henry V. Chase</b>				M.D. <b>4 E. Church St., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>23 Jan 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
JAN 4 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		DR. J. H. HARRIS	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		RELATIONSHIP		OCCUPATION		EDUCATION	
JAN 10 1968		MEMPHIS, TENNESSEE		F. B. I.		FATHER		BUSINESSMAN		HIGH SCHOOL	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		INTERVIEWED		INTERVIEWED		INTERVIEWED	
JAN 10 1968		MEMPHIS, TENNESSEE		F. B. I.		FATHER		BUSINESSMAN		HIGH SCHOOL	
DATE OF SIGNATURE		PLACE OF SIGNATURE		SIGNATURE		TITLE		OFFICE		DEPARTMENT	
JAN 10 1968		MEMPHIS, TENNESSEE		F. B. I.		FATHER		BUSINESSMAN		HIGH SCHOOL	

BUREAU V. S.

JAN 24 1957

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

616

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Unk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. STREET ADDRESS <b>65 S. Market Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>H</b> Last <b>Dodd</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 6/1909</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William R. Dodd</b>				14. MOTHER'S MAIDEN NAME <b>Maude Coffey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>223-14-4851</b>		17. INFORMANT Address <b>Hospital Records (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull with extensive</b> DUE TO <b>hemorrhage into</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>brain</b> DUE TO (c) <b>6 hrs.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down a long flight of stairs</b>					
20c. TIME OF INJURY Month, Day, Year <b>1/12/57</b> Hr. <b>10</b> or a.m. <b>X</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Frederick</b> (County) <b>Frederick</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>January 15 1957</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>18 Jan 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Baptist Cemetery</b>		22d. LOCATION (City, town, or county) <b>Avon, Virginia</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>17 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Hebe</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
John		Male		45		White		Jan 18, 1957	
Residence		Occupation		Cause of Death		Manner of Death		Place of Death	
1000 North Street		Teacher		Heart Disease		Natural		Home	
City		County		State		Federal District		Country	
Baltimore		Baltimore		Maryland		District of Columbia		United States	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
Jan 18, 1957		Jan 18, 1957		Jan 18, 1957		Jan 18, 1957		Jan 18, 1957	

BUREAU V. 3

JAN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

006181

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville-Rural-R.D.#1</b>		c. LENGTH OF STAY IN 1b <b>55 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 Knoxville-Rural-R.D.#1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Brunswick</b>				d. STREET ADDRESS <b>Near Brunswick</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMANDA LENORA EAGLE</b>				4. DATE OF DEATH Month Day Year <b>January 30, 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 20, 1888</b>		9. AGE (In years last birthday) yrs. <b>68</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert A. Kefauver</b>				14. MOTHER'S MAIDEN NAME <b>Alta Z. Kepler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. G. Maynard Eagle, Knoxville R.F.D.#1, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Cerebral Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>4 y 10</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1952</b> to <b>1/30, 1957</b> , that I last saw the deceased alive on <b>1/16, 1957</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. Brice</b>		M.D. <b>Jefferson, Maryland</b>				DATE SIGNED <b>2/1/1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. T. Brice</b>		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>2 Feb 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 210 1-29-57 ams

617

## CERTIFICATE OF DEATH

Reg. Dist. No.

00620  
131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN b <b>2 da</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Thurmont</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NEWTON</b> Middle <b>ISIAH</b> Last <b>FISHER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>II.</b> Year <b>1957</b> 19			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 6. 1869</b>	
9. AGE (In years birthdate) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House painter</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co., MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>David Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Moriah Stockalger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>George Wilhide Emmitsburg. MD</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis with Uraemia; Benign Prostatic Hypertrophy</b> <b>Broncho Pneumonia</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>several weeks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-9-1957</b> to <b>1-11-1957</b> that I last saw the deceased alive on <b>19</b> and that death occurred at <b>4 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick, Md</b> DATE SIGNED ACTUAL SIGNATURE <b>A.A. Pearce</b> M.D. <b>Fredrick, Md</b> PHYSICIAN'S NAME (Type) <b>A.A. Pearce</b>							
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 14 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont. Fredk. Co MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b> ADDRESS <b>Thurmont. MD</b>				24a. REC'D BY REGISTRAR DATE <b>15 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heub</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED T. J. O'NEILL		SEX Male		AGE 34		DATE OF BIRTH JAN. 11, 1923	
PLACE OF BIRTH BALTIMORE, MD		RACE White		EDUCATION High School		OCCUPATION None	
RESIDENCE 1000 N. E. ST., BALTIMORE, MD		MARRIAGE Married		DATE OF MARRIAGE JAN. 11, 1945		NAME OF SPOUSE J. M. O'NEILL	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DATE OF DEATH JAN. 16, 1957		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN J. M. O'NEILL		SIGNATURE OF REGISTRAR J. M. O'NEILL		DATE JAN. 16, 1957		PLACE BALTIMORE, MD	

BUREAU V. S.

JAN 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00621

618

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>257 West Fifth Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>LOUISE</b> Last <b>GAVER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ira Bond</b>		14. MOTHER'S MAIDEN NAME <b>Belva Stottlemeyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-9985</b>		17. INFORMANT <b>Stabley V. Gaver, 814 Toll House Avenue, Frederick, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fibrosarcoma of lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-1-</b> , <b>1956</b> , to <b>1-4</b> , <b>1957</b> , that I last saw the deceased alive on <b>12-31-</b> , <b>1956</b> , and that death occurred at <b>10:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church St., Frederick, Md.</b> DATE SIGNED <b>1/7/1957</b> ACTUAL SIGNATURE <b>R. R. Martin</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth Heck</b>	

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. OCCUPATION [Illegible]</p>		<p>11. MARITAL STATUS [Illegible]</p>		<p>12. EDUCATION [Illegible]</p>	
<p>13. PREVIOUS ILLNESS [Illegible]</p>		<p>14. MEDICAL HISTORY [Illegible]</p>		<p>15. PHYSICIAN'S SIGNATURE [Illegible]</p>	
<p>16. CORONER'S SIGNATURE [Illegible]</p>		<p>17. COUNTY CLERK'S SIGNATURE [Illegible]</p>		<p>18. REGISTRAR'S SIGNATURE [Illegible]</p>	

BUREAU V. E.

JAN 8 1957

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>West Main</b>		d. STREET ADDRESS <b>West Main</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rhoda Hannah Gillelan</b>		4. DATE OF DEATH Month Day Year <b>January 26 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George L. Gillelan</b>		14. MOTHER'S MAIDEN NAME <b>Ida S. Ohler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ruth B Gillelan</b>		Address <b>West Main Street Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Liver with metastases</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>malnutrition</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-9-</b> , 19 <b>56</b> , to <b>Jan 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 25</b> , 19 <b>57</b> , and that death occurred at <b>1:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles R Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>Emmitsburg, Md</b>	
DATE SIGNED <b>1-26-57</b>			
PHYSICIAN'S NAME (Type) <b>Charles R Williams</b>		<b>Emmitsburg, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Elias Lutheran</b>	22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>		ADDRESS <b>Emmitsburg, Md.</b>	24a. REC'D BY REGISTRAR <b>Jan 29 57</b>
		24b. REGISTRAR'S SIGNATURE <b>West</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 29 1957

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

649

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flint Hill</b>		c. LENGTH OF STAY IN 1b <b>All of life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flint Hill Adamstown R.F.D.I.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsworth</b> Middle <b>Lorraine</b> Last <b>Griffith</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 12, 1956</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick-Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ralph Franklin Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Lena May Proctor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Adamstown R.F.D. I. Lena May Proctor Griffith</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 2 hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Valvular Heart Defect</b> 2 months DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>FEB. 25 57</b>		<b>HOPE HILL</b>		<b>Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. E. Hicks</b>				ADDRESS <b>Frederick-Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 4 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ely. Hicks</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the records of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Frederick

January 1, 1911

All of age

1111

Male

Colored

Frederick M. J.

John Frederick

John Frederick

John Frederick

John Frederick

John Frederick

BUREAU V. S.

FEB 4 1957

RECEIVED

RECEIVED  
FEB 5 1957  
HALL HILL  
J. E. HICKS III  
Frederick M. J.

619 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 Weeks</b>		c. <del>CITY</del> OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Jefferson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crutchley Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LYDIE</b> Middle <b>CATHERINE</b> Last <b>GROVE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 3, 1870</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Hildebrand</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Winpegler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Grover Cline - Hagerstown, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auricular Fibrillation Myocardial Infarction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/4</b> , 19 <b>57</b> , to <b>1/31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/30</b> , 19 <b>57</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. Brice</b>				M.D. <b>Jefferson, Maryland</b>		DATE SIGNED <b>2/2/1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. A. T. Brice</b>				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>4 Feb 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heisk</b>			



CERTIFICATE OF DEATH

PLACE OF DEATH HOME		COUNTY SUFFOLK	
CITY BOSTON		STATE MASSACHUSETTS	
DECEASED JOHN J. BROWN		SEX MALE	
AGE 68		DATE OF BIRTH 1889	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH FEBRUARY 3, 1957		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH IRELAND		DATE OF ARRIVAL 1900	
NAME OF PHYSICIAN DR. J. J. BROWN		NAME OF HOSPITAL ST. JOSEPH'S HOSPITAL	
NAME OF FUNERAL HOME J. J. BROWN & SONS		NAME OF BURIAL PLACE ST. JOSEPH'S CEMETERY	
NAME OF NEXT OF KIN MRS. J. J. BROWN		NAME OF WITNESS DR. J. J. BROWN	
SIGNATURE OF DECEASED (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF FUNERAL HOME (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF HOSPITAL (None)	
SIGNATURE OF BUREAU (None)		SIGNATURE OF DEPARTMENT (None)	

BUREAU V. 8

FEB 5 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00625/21

620

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary M Heier</u>				4. DATE OF DEATH Month Day Year <u>Jan 26 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1896</u>	9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marshall Michael</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Morris Heier Myersville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>5 yrs +</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/24</u> , 1957, to <u>1/26</u> , 1957, that I last saw the deceased alive on <u>1/25</u> , 1957, and that death occurred at <u>6:40</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				DATE SIGNED <u>1/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Cramer</u>				ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. G. Hicks</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JAN 30 1957

RECEIVED

650

## CERTIFICATE OF DEATH

00626

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>860 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		d. STREET ADDRESS <b>102 Frederick Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Lula Houston</b>		4. DATE OF DEATH Month Day Year <b>January 24 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Kline</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Profit</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Deceased</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 17 1954</b> , to <b>January 24 1957</b> , that I last saw the deceased alive on <b>January 24 1957</b> , and that death occurred at <b>3:04 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Cullen, Maryland January 25, 1957</b>			
ACTUAL SIGNATURE <i>I. B. Lyon</i>		M.D. <b>Cullen, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>I. B. Lyon, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/26/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Bailey</i>		ADDRESS <b>Frederick Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 1/25/57</b>		24b. REGISTRAR'S SIGNATURE <i>W. Bailey</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

621

## CERTIFICATE OF DEATH

00627

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>115 East Fifth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 Sept 1880</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Isaac Pleasant</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John E. Pleasant (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>26 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.2 Arteriosclerosis heart disease, Nephrosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1</b> , 19 <b>26</b> to <b>Jan 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 26</b> , 19 <b>57</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D. <b>4 W. 3rd St., Frederick, Md.</b>				DATE SIGNED <b>26 Jan 1957</b>			
PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>29 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heick</b>	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Signature of Coroner	
John Doe		Male		45		Jan 1, 1912		Jan 15, 1957		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Occupation		14. Education		15. Marital Status		16. Social Security Number		17. Race		18. Religion		19. Place of Death		20. Time of Death		21. Name of Hospital		22. Name of Doctor		23. Name of Nurse		24. Name of Embalmer	
Teacher		High School		Married		123-45-6789		White		Catholic		Baltimore, Md.		10:00 AM		St. Mary's Hospital		Dr. Smith		Mrs. Jones		Mr. Brown	
25. Name of Undertaker		26. Name of Funeral Home		27. Name of Cemetery		28. Name of Grave		29. Name of Interment		30. Name of Burial		31. Name of Cremation		32. Name of Ashes		33. Name of Urn		34. Name of Casket		35. Name of Coffin		36. Name of Vault	
Mr. Green		Mr. Green		St. Mary's Cemetery		Block 12, Lot 45		Interment		Burial		Cremation		Ashes		Urn		Casket		Coffin		Vault	

RECEIVED  
JAN 21 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00628

651

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Braddock Heights</i>	c. LENGTH OF STAY in 1b <i>8 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Vindobona Convalescent Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS <i>507 Wilson Place</i>
3. NAME OF DECEASED (Type or print) First <i>Bessie</i> Middle <i>Lee</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>January</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-1889</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>	11. BIRTHPLACE (State or foreign country) <i>Orient Iowa</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Business College</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Everett Kellogg</i>		14. MOTHER'S MAIDEN NAME <i>Mary ? Kellogg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>579-28-4359</i>	
17. INFORMANT <i>Mrs. Owen E. Jones - 507 Wilson Place Frederick - Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>490x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Lobar pneumonia</i> DUE TO (c) <i>Cerebral thrombosis</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>10 1/2 hours</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 12, 1956</i> , to <i>Jan 30, 1957</i> , that I last saw the deceased alive on <i>Jan 29, 1957</i> , and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. R. Schoolman</i>		ADDRESS (Street, city or town, state) <i>225 N. Market St. Frederick - Maryland</i>	
PHYSICIAN'S NAME (Type) <i>L. R. Schoolman</i>		DATE SIGNED <i>1-30-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2-2-1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline &amp; Son</i>		24a. REC'D BY REGISTRAR <i>Elizabeth G. Heck</i>	
ADDRESS <i>Frederick - Md.</i>		24b. REGISTRAR'S SIGNATURE	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CEMETERY</p>	
<p>21. SIGNATURE OF CHURCH</p>		<p>22. SIGNATURE OF MINISTRY</p>	
<p>23. SIGNATURE OF CLERGY</p>		<p>24. SIGNATURE OF RABBI</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
<p>31. SIGNATURE OF OTHER</p>		<p>32. SIGNATURE OF OTHER</p>	
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<p>77. SIGNATURE OF OTHER</p>		<p>78. SIGNATURE OF OTHER</p>	
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<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
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<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

BUREAU V. B.

FEB 5 1957

RECEIVED

## 652 CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE ROUTER</b>				c. LENGTH OF STAY IN 1b <b>YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CARROLL EDWARD JONES</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>COL</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 19-1905</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PERRY F JONES</b>				14. MOTHER'S MAIDEN NAME <b>IRENE MILBERRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-05-1717</b>		17. INFORMANT <b>WILLIAM JONES</b> Address <b>UNION BRIDGE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, bronchogenic, left lower lobe</b> <b>162X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C metastatic to pleura &amp; pleural effusion</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 November 1955</b> , to <b>23 January 1957</b> , that I last saw the deceased alive on <b>22 January 1957</b> , and that death occurred at <b>AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Walpersville, Md</b> DATE SIGNED <b>24 Jan 1957</b>							
ACTUAL SIGNATURE <b>James E. Hosen, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Walpersville, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN 26-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OLDFIELDS</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hartzler &amp; Sons</b>				ADDRESS <b>Union Bridge, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 28 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Eugenia Barker</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG211 3-1-57 et

00630

622

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILLARD</b> Middle <b>JOSEPH</b> Last <b>KEMP</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884</b> <b>22 March 1884</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employed Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William L. Kemp</b>				14. MOTHER'S MAIDEN NAME <b>Malinda Lambert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Virgie M. Kemp (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal aortic aneurysm with rupture 6 hours</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>12-1-</b> , 19 <b>53</b> , to <b>1-17-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-17-</b> , 19 <b>57</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E. Church St., Frederick, Md.</b> DATE SIGNED <b>1-19-57</b>							
ACTUAL SIGNATURE <b>Rex R. Martin</b> M.D. <b>35 E. Church St., Frederick, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>21 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>21 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hecks</b>	

## CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
MARVELL		JAN 22 1957		BATHING	
AGE		SEX		RACE	
18		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 22 1939		BATHING		U.S.A.	
OCCUPATION		EDUCATION		MARRIAGE	
BATHING		HIGH SCHOOL		MARRIED	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE	
JAN 22 1957		10:00 AM		BATHING	

BUREAU V. S.

JAN 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

623

## CERTIFICATE OF DEATH

Reg. Dist. No.

19631

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt # 2 Keymar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>69 Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>06812</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond S Lambert</u>				4. DATE OF DEATH Month Day Year <u>Jan 17 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/92</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Lambert</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Geesey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-9537</u>		17. INFORMANT Address <u>Mrs. Mary Lambert, Keymar, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/13</u> , 19 <u>57</u> , to <u>1/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/16/57</u> , 19 <u>57</u> , and that death occurred at <u>4:34</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E Church St</u>		DATE SIGNED <u>1/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Henry V Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				ADDRESS <u>Middletown, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 21 Jan 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heisk</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CHURCH CLERGYMAN		18. SIGNATURE OF BURIAL OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INVESTIGATOR		23. SIGNATURE OF SUPERVISOR		24. SIGNATURE OF ASSISTANT SUPERVISOR		25. SIGNATURE OF CLERK		26. SIGNATURE OF RECEPTIONIST		27. SIGNATURE OF TELEPHONE OPERATOR		28. SIGNATURE OF MAIL ROOM		29. SIGNATURE OF RECORDS SECTION		30. SIGNATURE OF IDENTIFICATION SECTION		31. SIGNATURE OF LABORATORY		32. SIGNATURE OF RADIOLOGY		33. SIGNATURE OF PATHOLOGY		34. SIGNATURE OF ANATOMY		35. SIGNATURE OF HISTOLOGY		36. SIGNATURE OF CYTOLOGY		37. SIGNATURE OF MICROBIOLOGY		38. SIGNATURE OF IMMUNOLOGY		39. SIGNATURE OF SEROLOGY		40. SIGNATURE OF CLINICAL CHEMISTRY		41. SIGNATURE OF CLINICAL PHYSIOLOGY		42. SIGNATURE OF CLINICAL PSYCHOLOGY		43. SIGNATURE OF CLINICAL SOCIAL WORK		44. SIGNATURE OF CLINICAL NURSING		45. SIGNATURE OF CLINICAL PHARMACY		46. SIGNATURE OF CLINICAL DIETETICS		47. SIGNATURE OF CLINICAL RECREATION		48. SIGNATURE OF CLINICAL ARTS		49. SIGNATURE OF CLINICAL MUSIC		50. SIGNATURE OF CLINICAL DANCE		51. SIGNATURE OF CLINICAL THEATRE		52. SIGNATURE OF CLINICAL FILM		53. SIGNATURE OF CLINICAL PHOTOGRAPHY		54. SIGNATURE OF CLINICAL RECORDS		55. SIGNATURE OF CLINICAL LIBRARY		56. SIGNATURE OF CLINICAL MUSEUM		57. SIGNATURE OF CLINICAL GALLERY		58. SIGNATURE OF CLINICAL BOTANICAL GARDEN		59. SIGNATURE OF CLINICAL ZOOLOGICAL GARDEN		60. SIGNATURE OF CLINICAL HERBARIUM		61. SIGNATURE OF CLINICAL MUSEUM OF NATURAL HISTORY		62. SIGNATURE OF CLINICAL MUSEUM OF ANTHROPOLOGY		63. SIGNATURE OF CLINICAL MUSEUM OF ARTS		64. SIGNATURE OF CLINICAL MUSEUM OF SCIENCE		65. SIGNATURE OF CLINICAL MUSEUM OF TECHNOLOGY		66. SIGNATURE OF CLINICAL MUSEUM OF INDUSTRY		67. SIGNATURE OF CLINICAL MUSEUM OF AGRICULTURE		68. SIGNATURE OF CLINICAL MUSEUM OF FISHERY		69. SIGNATURE OF CLINICAL MUSEUM OF MINING		70. SIGNATURE OF CLINICAL MUSEUM OF METALLURGY		71. SIGNATURE OF CLINICAL MUSEUM OF CHEMISTRY		72. SIGNATURE OF CLINICAL MUSEUM OF PHYSICS		73. SIGNATURE OF CLINICAL MUSEUM OF MATHEMATICS		74. SIGNATURE OF CLINICAL MUSEUM OF MEDICINE		75. SIGNATURE OF CLINICAL MUSEUM OF DENTISTRY		76. SIGNATURE OF CLINICAL MUSEUM OF VETERINARY MEDICINE		77. SIGNATURE OF CLINICAL MUSEUM OF AGRICULTURAL MECHANICS		78. SIGNATURE OF CLINICAL MUSEUM OF AERONAUTICS		79. SIGNATURE OF CLINICAL MUSEUM OF NAUTICS		80. SIGNATURE OF CLINICAL MUSEUM OF ASTRONAUTICS		81. SIGNATURE OF CLINICAL MUSEUM OF COSMOS		82. SIGNATURE OF CLINICAL MUSEUM OF UNIVERSE		83. SIGNATURE OF CLINICAL MUSEUM OF GOD		84. SIGNATURE OF CLINICAL MUSEUM OF MAN		85. SIGNATURE OF CLINICAL MUSEUM OF NATURE		86. SIGNATURE OF CLINICAL MUSEUM OF LIFE		87. SIGNATURE OF CLINICAL MUSEUM OF DEATH		88. SIGNATURE OF CLINICAL MUSEUM OF REBIRTH		89. SIGNATURE OF CLINICAL MUSEUM OF RESURRECTION		90. SIGNATURE OF CLINICAL MUSEUM OF GLORY		91. SIGNATURE OF CLINICAL MUSEUM OF HONOR		92. SIGNATURE OF CLINICAL MUSEUM OF POWER		93. SIGNATURE OF CLINICAL MUSEUM OF WEALTH		94. SIGNATURE OF CLINICAL MUSEUM OF KNOWLEDGE		95. SIGNATURE OF CLINICAL MUSEUM OF WISDOM		96. SIGNATURE OF CLINICAL MUSEUM OF FAITH		97. SIGNATURE OF CLINICAL MUSEUM OF HOPE		98. SIGNATURE OF CLINICAL MUSEUM OF CHARITY		99. SIGNATURE OF CLINICAL MUSEUM OF LOVE		100. SIGNATURE OF CLINICAL MUSEUM OF GOD	
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BUREAU V. S.

JAN 22 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

653

## CERTIFICATE OF DEATH

00632

Reg. Dist. No. 139

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>				c. LENGTH OF STAY IN 1b <b>95 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>				d. STREET ADDRESS <b>2001 Ashton St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Lewrenz</b> Last <b>Lewrenz</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1895</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>13</b> Hours <b>13</b> Min.		IF UNDER 24 HRS. Months <b>61</b> Days <b>13</b> Hours <b>13</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Patrol</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Albert Lewrenz</b>				14. MOTHER'S MAIDEN NAME <b>Augusta ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-32-9713</b>		17. INFORMANT <b>Deceased</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c) <b>002X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Tuberculosis. Carcinoma of larynx.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cullen</b>				20g. (County) <b>Cullen</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>October 15, 1956</b> , to <b>January 13, 1957</b> , that I last saw the deceased alive on <b>January 13, 1957</b> , and that death occurred at <b>6:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>I. B. Lyon</i>				DATE SIGNED <b>January 13, 1957</b>			
PHYSICIAN'S NAME (Type) <b>I. B. Lyon, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/16/57</b>		22b. DATE THEREOF <b>1/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Cragg</i>				ADDRESS <i>Thurmont Md</i>		24a. REC'D BY REGISTRAR DATE <b>1/13/57</b>	
24b. REGISTRAR'S SIGNATURE <i>I. B. Lyon</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



624

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>F</i> Last <i>Lewis</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>6</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-31-1864</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>general laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>general</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Jacob Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Celia Hurley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Ray DeLentur</i> Address <i>Myersville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchopneumonia</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov</i> 19 <i>56</i> , to <i>Jan 6</i> 19 <i>57</i> , that I last saw the deceased alive on <i>Jan 5</i> 19 <i>57</i> , and that death occurred at <i>7:30</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D.		ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>1/6/57</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		<i>Frederick Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-8-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Greenacres Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Co. Middletown, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR <i>8 Jan 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 90634

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>B.</u> Last <u>Lighter</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
10a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred H. Routzahn</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hagan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Anna Axline, Brunswick, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis (Heart Disease)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u> <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>57</u> , to <u>1/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V Chase</u>		DATE SIGNED <u>1/29/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Henry V. Chase</u>		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1 Feb. 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hech</u>			



BUREAU V. S.

FEB 4 1957

RECEIVED

## 626 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>May</u> Last <u>Lowman</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/25/74</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Haines</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH LAMBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Earl Gamber Walkersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Fracture left hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years</u> <u>27 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12 25</u> 1956 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) (County) (State) <u>Frederick</u>							
21. I certify that I attended the deceased from <u>12/25/1956</u> to <u>1/21/1957</u> , that I last saw the deceased alive on <u>1/21/1957</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Pilgram</u> M.D.				ADDRESS (Street, city or town, state) <u>Professional Bldg. Frederick, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert H. Pilgram</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan 24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Hartzler &amp; Sons Union Bridge, Md</u>				24a. REC'D BY REGISTRAR DATE <u>25 Jan 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00636

131

627

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1143 West Patrick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>MAY</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>January 11</b> , Day <b>11</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 May 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>71</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pantry Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas H. Glessner</b>		14. MOTHER'S MAIDEN NAME <b>Alice Adora Barrick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-24-5707</b>	
17. INFORMANT <b>Mathias B. Miller, Sr.,</b> Address <b>(Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Chronic Edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 1956, to <b>Jan 11</b> , 1957, that I last saw the deceased alive on <b>Jan 11</b> , 1957, and that death occurred at <b>6:40A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 E 2nd St., Frederick, Md.</b> DATE SIGNED <b>11 Jan 1957</b>			
ACTUAL SIGNATURE <b>H. Lawrence Fahrney</b> M.D.			
PHYSICIAN'S NAME (Type) <b>H. Lawrence Fahrney, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>15 Jan 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>12 Jan 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00637

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN lb <b>10 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>06 X 22</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>JACOB</b> Last <b>NEWMAN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 Jan 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.		IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Milling &amp; Supply Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jacob M. Newman</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Shaw</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Grace Haller Newman</b> Address <b>(Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Skull</b> DUE TO <b>Subdural Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>900.0</b> (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down cement steps &amp; struck on cement pavement</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. m. <b>Jan 21</b> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>23 Jan 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>24 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 23 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 24 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

629

## CERTIFICATE OF DEATH

Reg. Dist. No.

98638

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BUCKEYS TOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>M. Edgar Read</u> First Middle Last <u>NICODEMUS</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1871</u>	
9. AGE (In years (Last birthday) yrs.) <u>85</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MFG. (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ICE CREAM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>AUGUSTUS W. NICODEMUS</u>			
14. MOTHER'S MAIDEN NAME <u>BARBARA FULTON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO. <u>212-14-7999</u>				17. INFORMANT Address <u>Buckeystown - Md.</u> <u>Miss Dorothy A. Nicodemus</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 30, 1956</u> , to <u>Jan 5, 1957</u> , that I last saw the deceased alive on <u>Jan 5, 1957</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>1/5/57</u>							
ACTUAL SIGNATURE <u>A. A. Pearce</u> M.D.				PHYSICIAN'S NAME (Type) <u>A. A. Pearce</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline &amp; Son - Frederick - Md.</u> ADDRESS <u>Frederick - Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Jan. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 209 1-11-57 ams		STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		00639	
630		CERTIFICATE OF DEATH		Reg. Dist. No. 131	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy 06X22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martin Luther Nicodemus		4. DATE OF DEATH Month Day Year January 4 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 8, 1874		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Heating & Plumbing Cont.		10b. KIND OF BUSINESS OR INDUSTRY Unionville, Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Martin L. Nicodemus		14. MOTHER'S MAIDEN NAME Lucinda Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs Wm. H. Browning, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm abdominal aorta 3/4 chronic nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Dec 19 1956, to January 4 1957, that I last saw the deceased alive on January 3, 1957, and that death occurred at 1:35 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Justin Pearse M.D.		ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED Jan 4 1957	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Pine Grove	
22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Chas L. N. Polunowith		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE Jan. 1957	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heick					



JAN 8 1957

RECEIVED

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 1-31-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00640

131

1. PLACE OF DEATH o. COUNTY <u>Fredrick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>		c. LENGTH OF STAY IN 1b <u>MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keymar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Fredrick County Chronic Hospital</u>				d. STREET ADDRESS <u>06X12</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Rosalie Nusbaum</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 1889 67 yrs</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>4</u> Hours <u>10</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Sappington</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Fryer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CLINTON E NUSBAUM, JOHNSVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralysis agitans</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>57</u> , to <u>Jan 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. K. Keim</u>				DATE SIGNED <u>Jan 22 1957</u>			
PHYSICIAN'S NAME (Type) <u>H. K. Keim</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 25 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hutzler &amp; Sons</u>				ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>25 Jan 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

JAN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 16 Film G209 1-24-57 et

Reg. Dist. No.

00641

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick-Route 2</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2 Rural-Frederick-Route 1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL JAMES O'BRYAN</b>		4. DATE OF DEATH Month Day Year <b>January 19 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8-1881</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas W. O'Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Annie Knight</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-2066</b>	
17. INFORMANT <b>Miss Maggie Perkins (Niece) Nr. Frederick-Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B.O. Thomas-Sr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Jan. 21-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 22-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Cline &amp; Son</b>		ADDRESS <b>Frederick-Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE 22 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>	

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00642

Reg. Dist. No. 131

655

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#6</b>				c. LENGTH OF STAY IN 1b <b>Months</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Frederick</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARSHALL</b> Middle <b>THOMAS</b> Last <b>ODEN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Oct 1919</b>	9. AGE (In years last birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>26</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas D. Oden</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Zepp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-16-0252</b>		17. INFORMANT <b>Mrs. Margaret K. Oden</b> (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARBON MONOXIDE POISONING</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Attached Hose to Exhaust of Auto-Fred'k-Rural Frederick Md.</b>					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 28 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hoch</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

JAN 29 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00643

Reg. Dist. No.

131

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Fredrick</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>		c. LENGTH OF STAY IN 1b <u>12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fredrick Memorial Hospital</u>				d. STREET ADDRESS <u>4418 St George Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Samuel</u> Middle <u>L.</u> Last <u>Oram</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>4</u> Year <u>1957</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>July 23, 1989</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>carpenter</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Edmund B Oram</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Adelaide Chambers</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>Records of Fredrick Memorial Hospital</u>				<b>17. INFORMANT</b> <u>Records of Fredrick Memorial Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>430.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. <u>0</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>B. C. Thomas</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>B. C. Thomas</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>Jan 4, 1957</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Jan 8/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lawrence Memorial Park</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Laurel</u>		<b>(State)</b> <u>md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Milton E. Elieker</u>				<b>ADDRESS</b> <u>1124 N. Caroline St</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>Jan 7, 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Cliff G. Kelly</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00644

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>832 North Market Street</b>				d. STREET ADDRESS <b>832 North Market Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>VERNON</b> Last <b>PHEBUS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 5, 1913</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b>	IF UNDER 24 HRS. Hours <b>43</b> Min. <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watch Repair</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry G. Phebus</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Irene Fox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-16-0318</b>		17. INFORMANT Address <b>Mrs. Barbara H. Phebus—See Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC CONGESTION WITH PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Marked ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>18 Hours</b>  <b>5 Years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick, Maryland</b>		20g. (County) <b>Frederick</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas Sr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Jan. 31, 1957</b>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>1957 Feb. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	



RECEIVED  
FEB 7 1957

FEB 4 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00645

634

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>GARLAN</b> Last <b>PLUMMER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 11, 1873</b>		9. AGE (In years low birthday) yrs. <b>83</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Thomas R. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth G. Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Roger G. Plummer, Adamstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart dis.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>10+ yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia; Uremia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>47</b> , to <b>Jan</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>28 January, 1957</b> , and that death occurred at <b>1:22 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles H. Conley Jr.</b> M.D. <b>Professional Bldg., Frederick, Md. 1/30/1957</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>Dr. Charles H. Conley Jr.</b> Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>24 Feb. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herb</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MAYNARD		MALE		38		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		35		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		32		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		30		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		28		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		26		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		24		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		22		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		20		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		18		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		16		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		14		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		12		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		10		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		8		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		6		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		MALE		4		JAN 15 1919		BALTIMORE, MARYLAND	
MAYNARD		FEMALE		2		JAN 15 1919		BALTIMORE, MARYLAND	

BUREAU V. 3

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00646

656

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>				c. LENGTH OF STAY IN 1b <b>Since 9/10/55</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Yellow Springs</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>ELIZABETH</b> Last <b>PLUMMER</b>				4. DATE OF DEATH Month <b>January 12,</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Aug 1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Kohlenberg</b>			
14. MOTHER'S MAIDEN NAME <b>Ellen Trout</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. J. C. Bryant (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Jan 8</b> , 19 <b>57</b> , to <b>Jan 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 12</b> , 19 <b>57</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. F. Kline</b>				M.D. <b>7 N. Market St., Frederick, Md. 1-15-57</b>			
PHYSICIAN'S NAME (Type) <b>H. F. Kline, M. D.</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>16 Jan 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 15 Jan 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

JAN 16 1957

BUREAU V.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 5 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00647

Item 18 Film 213 4-12-57 ams

# CERTIFICATE OF DEATH

Reg. Dist. No. 131

635

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cornwall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>5 1/2</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>134 Carter Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fleecie</u> Middle <u>Joy</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4, 1957</u>
9. AGE (In years last birthday) yrs. <u>3</u> Min. <u>30</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. David John Powell</u>		14. MOTHER'S MAIDEN NAME <u>Betty Jane Whipp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father (Mr. David Powell)</u>		Address <u>Sykesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>Fetal atelectasis</u> DUE TO <u>762.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal anemia, cause undetermined.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Jan 1957</u> to <u>4 Jan 1957</u> , that I last saw the deceased alive on <u>1 PM 4 Jan 1957</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Guest</u> M.D.		ADDRESS (Street, city or town, state) <u>7 E. Church St. Frederick Md</u> DATE SIGNED <u>4 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>R. L. Guest MD</u>		<u>7 E. Church St. Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 6, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS <u>2069 28th St</u>	
24a. REC'D BY REGISTRAR <u>Jan 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

CERTIFICATE OF DEATH

Reg. Dist. No. 131

00648

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN TB <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLINTON</u> Middle <u>EDWARD</u> Last <u>REMSBERG</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-11-1883</u>	
9. AGE (In years last birthday) <u>73 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington Remsberg</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hargett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-5300</u>		17. INFORMANT Address <u>208 Center St. Frederick, Md.</u> <u>Mrs. Clinton E. Remsberg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease - Obstructive Jaundice - Stomach Cancer</u> <u>420.9</u> DUE TO (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>							
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>56</u> , to <u>Jan 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>1/5/57</u> ACTUAL SIGNATURE <u>A. A. Pearce</u> M.D. <u>Frederick, Md.</u> PHYSICIAN'S NAME (Type) <u>A. A. Pearce</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline &amp; Son</u> ADDRESS <u>Frederick - Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hark</u>	

05-15074

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **131**

**00649**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b> c. LENGTH OF STAY IN lb <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 6</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b> d. STREET ADDRESS <b>Route 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>M A M I E M A D O R A Reynolds</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>Jan 15 1957</b> Month Day Year							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-18-1896</b>		<b>9. AGE</b> (In years last birthday) <b>60 yrs.</b> IF UNDER 1 YEAR: Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Stewart</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>220-01-2541</b>		<b>17. INFORMANT</b> <b>Charles L. Reynolds-127 Pa. Ave.-Frederick, Md.</b> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>593X</b> DUE TO <b>Acute Cardiac dilation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephritis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 yrs. +</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>4343</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>Dr. B.O. Thomas-Sr.</b> <b>EXAMINER'S NAME (Type)</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Jan. 19-1957</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Frederick- Maryland</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. E. Cline &amp; Son</b> <b>ADDRESS</b> <b>Frederick-Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>18 Jan 1957</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Elizabeth G. Heck</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.





## 637 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>New Market</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>RIPPEON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1880</b>	9. AGE (In years last birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Zacharias Rippeon</b>				14. MOTHER'S MAIDEN NAME <b>/1</b> <b>Mary Wison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-16-1994A</b>		17. INFORMANT <b>Mrs. Jennie F. Rippeon, New Market, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>2 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obstructive Jaundice due to Common Duct Stone</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 21, 1956</b> to <b>Jan 5, 1957</b> , that I last saw the deceased alive on <b>Jan 5, 1957</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John M. Culler</b>				ADDRESS (Street, city or town, state) <b>East Second St., Frederick, Md.</b> DATE SIGNED <b>1/7/1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. John M. Culler</b>				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lingnore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Unionville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Jan. 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 22.

RECEIVED

JAN 8 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00651

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick R.T. #3</u>		c. LENGTH OF STAY IN 1b <u>11</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>6 Clarke Place</u>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Franklin Blain Roberson</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>12</u> Year <u>1957</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 11, 1923</u>		<b>9. AGE</b> (In years last birthday) <u>33</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">F UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		F UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
F UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N.C.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.</u>											
<b>13. FATHER'S NAME</b> <u>JAMES F. ROBERSON</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>GRACE MARTIN</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>3-1-45-9-25-48-49-28-1148</u>		<b>17. INFORMANT</b> <u>Thomas Roberson</u> Address <u>5054 19th St N.E. Wash. D.C.</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Fracture base skull</u>  <u>816x</u> DUE TO             </td> <td rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>minutes</u> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="2"> <b>(b)</b> <u>Crushed right ribs + chest</u>  <b>DUE TO</b> </td> </tr> <tr> <td colspan="2"> <b>(c)</b> </td> <td></td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Fracture base skull</u> <u>816x</u> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>(b)</b> <u>Crushed right ribs + chest</u> <b>DUE TO</b>		<b>(c)</b>		
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Fracture base skull</u> <u>816x</u> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u>															
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>																	
<b>(b)</b> <u>Crushed right ribs + chest</u> <b>DUE TO</b>																	
<b>(c)</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Crossed white line, onto wrong lane, head on collision</u>															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>11</u> a. m. <u>Jan. 12</u> 19 <u>57</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 15</u>		<b>20f. (City or town)</b> <u>2 1/2 miles South of Frederick Md.</u> (County) <u>Frederick Md.</u> (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>B.D. Thomas</u>				<b>DATE SIGNED</b> <u>January 12-1957</u>													
<b>EXAMINER'S NAME (Type)</b> <u>B.D. Thomas</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1-16-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat.</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Arlington</u> (State) <u>VA.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lee Box Co</u>				<b>ADDRESS</b> <u>Wash. D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE</u>											
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>E. J. G. Hecker</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 17 1967

RECEIVED



## CERTIFICATE OF DEATH

00652

Reg. Dist. No. 131

659

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN lb <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				d. STREET ADDRESS <u>x 2 Mt. Airy</u>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>V</u> Last <u>Punkles</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/94</u>	
9. AGE (In years lost birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min.		IF UNDER 24 HRS. Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Henry Clay</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah C. Winsing</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>213-34-4849</u>				17. INFORMANT Address <u>Mrs Norman Watkins, Mt. Airy, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pyonephrosis due to A. aerogenes</u> DUE TO <u>663X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple lung abscesses due to A. aerogenes</u> DUE TO <u>260X Diabetes mellitus</u> (c) <u>260X Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 wks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E. Church St Frederick Md</u> DATE SIGNED <u>1/20/57</u>							
ACTUAL SIGNATURE <u>Henry V. Chase</u>		M.D. <u>4 E. Church St</u>		PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		ADDRESS <u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Wolsworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>Elizabeth S. Heik</u>	
24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heik</u>				DATE <u>24 Jan 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED COLLIER HENRY CLAY		SEX MALE	
AGE 62		DATE OF BIRTH JAN 28 1895	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER	
MARITAL STATUS SINGLE		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 28 1957		PLACE OF DEATH BALTIMORE, MD.	
TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. H. [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF BURIAL OFFICIAL [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

RECEIVED  
 JAN 28 1957  
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. KEADLE  
318 N. POTOMAC ST.  
HAGERSTOWN MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00653

660

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEAR WASH MONUMENT ST. PARK</b>		c. LENGTH OF STAY IN 1b		X. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NR. WASH. MONUMENT STATE PARK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 MIDDLETOWN MD. R.I.</b>				d. STREET ADDRESS <b>1 MIDDLETOWN MD. R.I.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES H. SMITH.</b>		First Middle Last		4. DATE OF DEATH <b>JANUARY 18 1957</b>		Month Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY - 1 - 1878</b>	
9. AGE (In years lost birthday) <b>78-6-17</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>ZITTELSTOWN WASH. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JONAS D. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET HUTZELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NOAHE</b>		17. INFORMANT <b>HUBERT F. SMITH MIDDLETOWN MD. R.I.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>↓</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Indef.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric hemorrhage not excluded</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1952, to death, 1957, that I last saw the deceased alive on <b>1-16</b> , 1956, and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert F. Keadle</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md 17804</b>				DATE SIGNED <b>17804</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT F. KEADLE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 20. 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BAST FUNERAL HOME</b>		ADDRESS <b>BOONSBORO MD.</b>		24a. REC'D BY REGISTRAR <b>JAN 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Ely G. Beck</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. PLACE OF BIRTH		14. OCCUPATION		15. EDUCATION	
16. MARITAL STATUS		17. RELIGION		18. RACE	
19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY		21. PREVIOUS TRAUMA	
22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER	
28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER	
31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER	
34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER	
40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER	
43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER	
46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER	
52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER	
55. PREVIOUS OTHER		56. PREVIOUS OTHER		57. PREVIOUS OTHER	
58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER	
64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER	
70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER	
76. PREVIOUS OTHER		77. PREVIOUS OTHER		78. PREVIOUS OTHER	
79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER	
82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER	
88. PREVIOUS OTHER		89. PREVIOUS OTHER		90. PREVIOUS OTHER	
91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER	
94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER	
97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER	

RECEIVED  
JAN 22 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 638 CERTIFICATE OF DEATH

Reg. Dist. No. 13

00654

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>12 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>411 Wilson Place</b>		d. STREET ADDRESS <b>411 Wilson Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Estelle</b> Last <b>Stone</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6-1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Brandenburg</b>		14. MOTHER'S MAIDEN NAME <b>Minerva Warrenfeltz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Raymond L. Stone- 615 Grant Pl.-Frederick-Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal Hemorrhage</b> <b>578x</b> DUE TO <b>(Undetermined origin)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 1950, to <b>Jan 24</b> , 1957, that I last saw the deceased alive on <b>Jan 23</b> , 1957, and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.-Frederick-Md.</b> DATE SIGNED <b>1-25-57</b> ACTUAL SIGNATURE <b>B.O. Thomas Jr.</b> M.D. <b>Professional Bldg.-Frederick-Md.</b> PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 27-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick-Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b> ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>26 Jan 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

JAN 29 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00655

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>21X22 Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard McDowell Violet</u>		4. DATE OF DEATH Month Day Year <u>January 19 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1928</u>
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Forest Grove Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer R. Violet</u>		14. MOTHER'S MAIDEN NAME <u>Martha Poffenberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes. 1949 - 1957</u>		16. SOCIAL SECURITY NO. <u>1949 - 1957</u>	
17. INFORMANT <u>Mrs. Rosalie S. Violet</u>		Address <u>Middletown Md. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken neck</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran into tree on 40A 1/2 mile East of Middletown</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour 8:25 a.m. 11/19/1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40A</u>	20f. (City or town) (County) (State) <u>Middletown Frederick Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Grove Wash. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Jan 24 1957</u>	
ADDRESS <u>Boonsboro Wash. Co. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Ely Hicks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: \_\_\_\_\_  
 SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 PLACE OF BIRTH: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 MANNER OF DEATH: \_\_\_\_\_  
 SIGNATURE OF EXAMINER: \_\_\_\_\_  
 DATE: \_\_\_\_\_

BUREAU V. S.

JAN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00656

## 640 CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 Petersville Road		d. STREET ADDRESS 312 Petersville Road	
3. NAME OF DECEASED (Type or print) First Geletta Middle - Last Virts		4. DATE OF DEATH Month I Day 21 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah Webber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Lillie Wigington, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 ya	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6, 1957 to Jan 21, 1957, that I last saw the deceased alive on Jan 3, 1957, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) J.G.F. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-57	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lu Felt		24a. REC'D BY REGISTRAR DATE 28 1957	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Eugenia Burky	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

DECEASED'S NAME

DECEASED'S RESIDENCE

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DECEASED'S NAME

DECEASED'S RESIDENCE

DECEASED'S NAME

DECEASED'S RESIDENCE

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DECEASED'S NAME

DECEASED'S RESIDENCE

BUREAU V. 3

JAN 28 1957

RECEIVED



CERTIFICATE OF DEATH

00657

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Fred. Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Raymond</i> Middle <i>W.</i> Last <i>Wiles</i>				4. DATE OF DEATH Month <i>1</i> Day <i>17</i> Year <i>1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>10-7-1889</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>7</i>		IF UNDER 24 HRS. Hours <i>17</i> Min. <i>57</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>public park</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Henry Wiles</i>				14. MOTHER'S MAIDEN NAME <i>Victoria Weddle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>214-10-3375</i>		17. INFORMANT <i>Mrs. Carrie Denninger</i> Address <i>731 Md. Ave. Hagerstown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>22 hrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>Jan 17</i> , 1957, to <i>Jan 17</i> , 1957, that I last saw the deceased alive on <i>Jan 17</i> , 1957, and that death occurred at <i>2:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>J. Elmer Harp</i> M.D. _____ PHYSICIAN'S NAME (Type) <i>Dr. J. Elmer Harp</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>1-21-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Pleasant Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Hagerstown</i> (State) <i>Md.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Shadhill Co.</i> ADDRESS <i>Middletown Md.</i>				24a. REC'D BY REGISTRAR <i>21 Jan 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

JAN 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

662

## CERTIFICATE OF DEATH

00658

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO</b>		c. LENGTH OF STAY IN 1b <b>38Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WOODSBORO</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>ELIZABETH</b> Last <b>WINEBRENNER</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>14th</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec, 31 - 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Myers</b>		14. MOTHER'S MAIDEN NAME <b>Catherine HOOVER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>*</b>	
17. INFORMANT <b>Mrs JEROME NULL</b>		Address <b>Woodsboro Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C. vascular disease</b> <b>422.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis &amp; Max epigastrum etiology undetermined</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Aug</b> , 19 <b>56</b> , to <b>14 Jan</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>13 January</b> , 19 <b>57</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>WALKERSVILLE, Md</b> DATE SIGNED <b>1/15/57</b>			
ACTUAL SIGNATURE <b>James E. Stoner Jr</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JAMES E. STONER JR WALKERSVILLE, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		22d. LOCATION (City, town, or county) (State) <b>WOODSBORO Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. E. Barton</b> ADDRESS <b>Walkersville Md</b>		24a. REC'D BY REGISTRAR <b>Elizabeth B. Heck</b> DATE <b>17 Jan. 1957</b>	

